Medi-Cal Managed Care: Is the Promise of Better Health Care Value Being Realized?

Managing the Continuum of Care in Medi-Cal
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A central goal of health care reform generally and the triple aim specifically is to improve health care value. In the emerging value-based health care economy all health care providers and plans will have to be able to demonstrate the relative health care value they provide. Medi-Cal is the nation’s largest Medicaid program and California’s largest health insurer. California began shifting Medi-Cal coverage from FFS to managed care in the early 1980s in the belief that health plans could provide higher quality care at lower cost – i.e., provide better health care value than FFS and achieve better health outcomes over time.
More than half of Medi-Cal members have been enrolled in managed care plans since 2005.

At present, little information exists to determine whether Medi-Cal managed care provides better health care value than FFS or whether over time it has improved health outcomes for Medi-Cal members.

My interest in determining whether Medi-Cal managed care is providing better health care value is twofold:

- It is an important policy and programmatic issue, and
- I am curious whether my judgment 30+ years ago was correct that managed care was a better way to provide care to Medi-Cal beneficiaries.
Presentation Objectives

- Introduce the Institute for Population Health Improvement
- Highlight recent trends in Medi-Cal membership growth and managed care coverage
- Review some Medi-Cal quality of care data
- Make some general observations based on available data
The Institute for Population Health Improvement
Since being established as an independent operating unit in the UC Davis Health System in mid-2011, the Institute for Population Health Improvement has:

- Developed a diverse portfolio of activities in 5 thematic areas:
  - Health care quality improvement
  - Data analytics and development of actionable health intelligence
  - Health leadership development
  - Health policy
  - Public health practice

- Focused primarily on assisting health-related government agencies and philanthropies design, implement, administer and/or evaluate programs

- Accrued approximately $85M in funded projects which support >80 FTE
Selected IPHI Activities

- Provide technical assistance and other support to the Department of Health Care Services and the Medi-Cal Program via the Medi-Cal Quality Improvement Program (MCQuIP)
- Manage the California Cancer Reporting and Epidemiologic Surveillance (CalCARES) Program
- Managed the California Health eQuality (CHeQ) Program - California’s federally funded Health Information Exchange Development Program
- Provide technical assistance and support for multiple CDPH chronic disease prevention and surveillance programs
- Conducted a statewide assessment of surgical adverse events and lead a surgical quality improvement collaborative
- Investigated the feasibility of developing Community Paramedicine in California
- Assisted CDPH achieve national accreditation
- Manage the California Health Policy Forum, Medi-Cal Data Symposia and Sacramento Policy Briefings Programs funded by the CHCF
- Supported the CHHSA in developing the State’s CalSIM proposal
How is Health Care Value Defined?

\[ V = \frac{A + TQ + FS + SS}{C} \]

- V = Value
- C = Cost/price
- A = Access or Accessibility
- TQ = Technical quality
- FS = Functional status
- SS = Service satisfaction
Some Medi-Cal Factoids

➢ California’s largest health insurer
➢ Provides health insurance coverage to >13 million Californians – one-third of the state’s population and half of its children
➢ Will expend approximately $95 B this year
➢ From FY 2011-12 to FY 2014-15, Medi-Cal
  ✓ Enrollment increased about 75% (7M to 12M)
  ✓ Expenditures increased about 109% ($43B to $90B)
➢ The average per capita expenditure for all Medi-Cal members in FY 2011-12 was $4,211, but it ranged from $0 for 13% of all enrollees (40% of FFS members) to $18.7M for the most expensive member
➢ Approximately 75% members now enrolled in 22 managed care plans
Number of Medi-Cal beneficiaries enrolled in managed care nearly doubled from 2009 and 2014

Data sources: Medi-Cal Enrollment data through January, 2014. Medi-Cal enrollment data obtained from California Department of Health Care Services, Research and Analytic Studies Division:
http://www.dhcs.ca.gov/dataandstats/statistics/Pages/RASD_Medi-Cal_Enrollment_Trends.aspx (Total Medi-Cal Certified Eligibles Tables)
Number of Medi-Cal managed care participating counties grew from 22 in 2005 to all 58 in 2013.
HIGHLIGHTS

Our audit of the CDHCS oversight of the Medi-Cal managed care health plans revealed the following:

- CDHCS did not verify health plan data; therefore, it cannot ensure that the health plans had adequate provider networks to serve Medi-Cal beneficiaries.
- It cannot be certain the quarterly adequacy assessments of provider networks that the California Department of Managed Health Care (Managed Health Care) performs on its behalf are based on accurate data.
- Provider directories for three health plans we reviewed—Anthem Blue Cross, Health Net, and Partnership HealthPlan—contained inaccurate information.
- Health Care Services needs to improve its processes for reviewing primary care provider directories.
- Thousands of calls from Medi-Cal beneficiaries to the Medi-Cal Managed Care Office of the Ombudsman, which was established to investigate and resolve complaints, have gone unanswered.
- Health Care Services has not consistently monitored health plans to ensure they meet Medi-Cal beneficiaries' medical needs.
  - It has not performed statutorily required annual medical audits of all health plans.
  - It has not always ensured that Managed Health Care has performed the required quarterly adequacy assessments.
Glimpses into Medi-Cal Quality of Care Data

- HEDIS results
- Health promotion interventions
- Cancer care
  - Stage at diagnosis, outcomes and quality of care
  - Utilization of gene expression profiling for breast cancer
The Health Effectiveness Data and Information Set (HEDIS) is a performance management tool used by more than 90% of U.S. health plans.

The DHCS has collected HEDIS data for Medi-Cal managed care plans for more than 10 years.

Medi-Cal has collected data on some 40 individual HEDIS measures for varying lengths of time; some of these measures have significantly changed in how they are calculated.

HEDIS data presented here are for measures which are:
- Currently being collected
- Have remained unchanged since 2005
- Have at least five years of results

HEDIS data presented here are for all plans combined; there is considerable variance between the top and lower performing plans which is not presented here.
Percent of members 3-to-6 years of age who received one or more well-child visits with a PCP during the measurement year: 2005-2014

HEDIS Child and Adolescent Health

Percent of children 2 years of age who had Immunization Combination 3 by their second birthday: 2008-2014

HEDIS Child and Adolescent Health

Percent of enrolled members between 3 and 17 years of age who had evidence of BMI percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year: 2010-2014

Percent of women who delivered a live birth who received a prenatal care visit as a member of the plan in the first trimester or within 42 days of enrollment in the plan: 2005-2014

HEDIS Women’s Health

Percent of women who delivered a live birth who completed a postpartum visit on or between 21 days and 56 days after delivery: 2005-2014

HEDIS Women’s Health

Percent of women 21 through 64 years of age who received one or more Pap tests within the prior three years: 2005-2013

Percent of members 18-75 years of age with diabetes who received a retinal or dilated eye exam during the measurement year or a negative retinal or dilated eye exam in the year prior to the measurement year: 2005-2014

Percent of members 18 through 75 years of age with diabetes who had an HbA1c test during the measurement year: 2006-2014

HEDIS Chronic Disease

Percent of members 18 through 75 years of age with diabetes who had LDL-C test during measurement year: 2006-2014

Percent of members 18 through 75 years of age with diabetes who received a screening test or had evidence of nephropathy during the measurement year: 2006-2014

Percent of members 18 through 75 years of age with diabetes whose most recent LDL-C test indicated an LDL-C level <100mg/dL during the measurement year: 2008-2014

Percent of members 18 through 75 years of age with diabetes whose most recent HbA1c test conducted during the measurement year showed a >9.0 percent HbA1C level, was missing or not done: 2008-2014

Percent of members 18 through 75 years of age with diabetes whose most recent HbA1c test conducted during the year showed an HbA1c level of <8.0%: 2010-2014

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<th>HbA1c Control (&lt;8.0%)</th>
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Data sources: California Department of Health Care Services, Medi-Cal Managed Care – Quality Improvements & Performance Measurement Reports, HEDIS 2010 through HEDIS 2014. [http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx](http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx)
HEDIS Medication Use and Other

Percent of members 18 to 64 years of age with primary diagnosis of acute bronchitis who were not dispensed an antibiotic prescription: 2008-2014

HEDIS Medication Use and Other

Percent of members who had a primary diagnosis of low back pain and who did not have an imaging study within 28 days of diagnosis: 2010-2014

Health promotion interventions judged to have the greatest impact on Medi-Cal members (e.g., healthful eating, physical activity, weight management, diabetes management) were delivered in various ways; educational materials, one-on-one education, and group classes were delivered most frequently.

Across all interventions, median educational hours were limited (2.4 h), and median Medi-Cal member participation was low (265 members per intervention).

Most interventions with greatest impact (120 of 137 [88%]) focused on tertiary prevention.

There were mixed results in referring members to community assistance programs and investing in community activities.
Conclusions

➢ Managed care plans have many opportunities to more effectively deliver health promotion interventions.
➢ Establishing measurable, evidence-based, consensus standards for such programs could facilitate improved delivery of these services.
The Rising Impact of Cancer

- Cancer is the leading cause of death in California and will be for the nation within about a decade.
- The cost of cancer care has risen disproportionately more than the rest of health care costs.
- Cancer will soon become the most expensive health care condition.
- In the past, about 8-10% of Medi-Cal expenditures have been for cancer.
Using data contained in the California Cancer Registry, this study evaluated stage at diagnosis, survival, and quality of care for 698,025 Californians with breast, colon, rectal, lung and prostate cancer from 2004 through 2012.

Payer source was assigned to one of 7 payer categories according to primary payer codes:
- Medicare
- Medi-Cal
- Medicare-Medi-Cal dual eligibles
- Private
- DOD
- VA
- Uninsured

These CCR data need to be linked with Medi-Cal paid claims and other data bases to better understand the findings.
Significant disparities in cancer survival and quality of care were found among persons having different sources of health insurance.

Substantial opportunities for improved quality of care were found for all payers.

The largest disparities were found among persons insured by Medi-Cal or having Medicare-Medi-Cal dual eligibility or having no insurance.

Medi-Cal patients having breast, colon and rectal cancer were more likely to be diagnosed at an advanced stage of disease and to have less favorable 5-year survival rates than persons having other sources of health insurance.

Medicare-Medi-Cal dual eligible patients were the least likely to receive recommended treatment for breast and colon cancer.

VA patients had the longest intervals between diagnosis and initiation of treatment for breast, colon, rectal, lung and prostate cancers, but their treatment outcomes compared favorably to patients with other types of health insurance and they were generally more likely to receive recommended treatment.
Disparities in Stage at Diagnosis, Survival, and Quality of Cancer Care in California by Source of Health Insurance: Breast Cancer

- Medi-Cal patients were least likely to be diagnosed at an early stage (39%); patients having DOD, private insurance, or Medicare coverage were significantly more likely to be diagnosed at stage 0 or I (62.3%, 61.4% and 60.4%, respectively).
- Medi-Cal patients were the least likely to receive breast-conserving surgery (52.2%), although the difference was not significantly different from VA and uninsured patients.
- Breast cancer patients under 70 years of age who were uninsured or had Medi-Cal coverage were least likely to receive recommended radiotherapy following breast-conserving surgery (64.4% and 65.2%, respectively), and VA patients were most likely to receive this recommended treatment (74.1%), although these differences were not statistically significant.
- VA patients were most likely to receive radiotherapy for positive regional lymph nodes following mastectomy (93.8%). Medicare and Medicare-Medi-Cal dual eligible patients were the least likely to receive this recommended treatment (49.6% and 46.8%, respectively), although not significantly less than uninsured patients.
Percentage of breast cancer cases with ≥4 positive regional lymph nodes for which radiation was considered or administered following a mastectomy.
Disparities in Stage at Diagnosis, Survival, and Quality of Cancer Care in California by Source of Health Insurance: Colon Cancer

- Medi-Cal and uninsured persons were less likely to be diagnosed at an early stage (20% and 18.1%, respectively) than persons having all other types of insurance.
- Medi-Cal and uninsured patients were the most likely to have colon cancer diagnosed at stage IV (31.9% and 28.7%, respectively), while VA patients were least likely to be diagnosed at a late stage (14.7%).
- DOD and VA colon cancer patients with stage III colon cancer were significantly more likely to be treated with adjuvant chemotherapy during the first course of treatment (83% and 82.4%, respectively), while Medicare-Medi-Cal dual eligible and Medicare patients were significantly less likely to receive this recommended treatment (51.1% and 53.7%, respectively).
- Medi-Cal patients had lower 5-year relative survival (56.6%) than all but Medicare patients.
Stage at Diagnosis - Colon

5-Year Relative Survival - Colon
Percentage of AJCC Stage III Colon Cancer Cases for whom Adjuvant Chemotherapy was Considered or Administered
Percentage of AJCC Stage II or III Resected Colon Cancer Cases for whom at least 12 regional lymph nodes were Removed or Pathologically Examined.
Disparities in Stage at Diagnosis, Survival, and Quality of Cancer Care in California by Source of Health Insurance: Rectal Cancer

- Medi-Cal patients were less likely to have rectal (including recto-sigmoid) cancer diagnosed at stage 0 or I (25.2%) than patients having Medicare, VA, Medicare-Medi-Cal dual-eligibility, and private insurance coverage.
- Privately insured patients were most likely to be diagnosed at an early stage (43%), although the difference was significant only when compared to Medi-Cal and uninsured patients.
- Medi-Cal patients were more than twice as likely to have rectal cancer diagnosed at stage IV (30.9%) compared to privately insured patients (14.4%)
- Medicare-Medi-Cal dual eligible patients with early stage rectal cancer had the lowest 5-year relative survival (65%).
Disparities in Stage at Diagnosis, Survival, and Quality of Cancer Care in California by Source of Health Insurance: 

**Lung Cancer**

- Medi-Cal and uninsured patients were significantly less likely to be diagnosed at an early stage (11.6% and 7.6%, respectively); DOD and VA patients were most likely to be diagnosed at stage I (26.4% and 24.5%, respectively).
- Uninsured and Medi-Cal patients were more likely to have their cancer diagnosed at stage IV (68.5% and 61.5%, respectively) than persons with other sources of insurance.
- Five-year relative survival for early stage lung cancer (stage 0 or I) was lower for Medi-Cal and Medicare-Medi-Cal dual eligible patients (48% and 46.1%, respectively) and highest for patients covered by DOD or private insurance (75.4% and 64.8%, respectively).
Disparities in Stage at Diagnosis, Survival, and Quality of Cancer Care in California by Source of Health Insurance: Prostate Cancer

- Medi-Cal patients were diagnosed with advanced (stage IV) prostate cancer more than three times as often as patients with private insurance or DOD coverage (18.6% compared to 5.6% and 5.7%, respectively).
- Five-year relative survival for metastatic prostate cancer (stage IV) was significantly lower for Medi-Cal patients (36.7%) than for those with VA, DOD or private insurance coverage.
Genetics
THE FUTURE IS NOW

New breakthroughs can cure diseases and save lives, but how much should nature be engineered?

NATIONAL CANCER INSTITUTE
PRECISION MEDICINE
IN CANCER TREATMENT

Discovering unique therapies that treat an individual's cancer based on the specific genetic abnormalities of that person's tumor.
71,864 persons were diagnosed with breast cancer in California during the 3-year period 2008-2010

68% (46% Stage I, 22% Stage IIa) were diagnosed at an early stage

The Oncotype Dx (ODX) assay can identify patients with node-negative, hormone receptor positive, and HER2 negative breast cancers who have low, intermediate and high risks for recurrence based on a calculated recurrence score

The ODx assay can identify patients who are most likely to benefit from adjuvant chemotherapy – and those who will not benefit and, thus, can be spared the morbidity associated with chemotherapy

Utilization of tumor gene expression assays in determining the course of treatment for node-negative, hormone receptor positive, HER2 negative breast cancer is generally considered to be the standard of care today

The ODx assay has been a Medi-Cal covered benefit since 2008
RESEARCH QUESTIONS

➢ What is the utilization of the Oncotype-DX assay among early stage breast cancer patients in California generally and in Medi-Cal members specifically?
➢ Were certain groups of patients more likely to receive the ODX assay?
➢ Is use of the ODX assay correlated with the type of treatment received?

STUDY METHODS

➢ The CCR was used to identify patients diagnosed with early stage breast cancer between Jan 2008 and Dec 2010.
➢ Patient identifiers were provided to the California DHCS
➢ DHCS linked the identifiers with the California Medi-Cal paid claims files to identify Medi-Cal members. DHCS returned this linked file to the CCR.
➢ CCR staff linked this file with a file provided by Genomic Health that identified patients receiving the ODX assay and the assay results.
➢ CCR staff removed all patient identifiers and created a de-identified linked file of patients for analysis.
USE OF THE ONCOTYPE DX ASSAY AMONG MEDI-CAL MEMBERS WITH BREAST CANCER – PRELIMINARY RESULTS

- 23,789 breast cancer patients diagnosed during the 3-year study period were eligible for the ODX assay; 8.5% of these were enrolled in Medi-Cal for at least one month (65% were enrolled for the entire period; 13% were enrolled for 6 months or less)

- About one-quarter (26.7%) of eligible breast cancer patients in California receive the ODX assay

- Medi-Cal members are less likely to receive the ODX assay than non-Medi-Cal members - 17.7% vs 27.5%

- Breast cancer patients older than 65 yrs are much less likely to receive the ODX assay than women younger than 50 (15% v 41%)

- Breast cancer patients residing in low SES census tracts are least likely to receive the ODX assay; use of the assay increased with higher SES status
Has the decision to shift Medi-Cal coverage largely to managed care resulted in higher quality care and the state realizing better health care value?
OVERALL OBSERVATIONS

➢ Medi-Cal is one of the largest health insurers in the nation.
➢ A large majority of Medi-Cal members are now enrolled in managed care.
➢ There is an incomplete understanding of the quality of care provided by Medi-Cal generally and by Medi-Cal managed care specifically.
➢ HEDIS data shows a substantial range of quality across Medi-Cal MCPs and overall mixed results with few examples of clearly improved outcomes over time; it is unclear how these data may have been affected by the recent marked growth in Medi-Cal membership.
➢ Health promotion activities have been implemented by Medi-Cal MCPs in a nonstandardized and uneven manner and have produced unclear outcomes.
➢ There appear to be numerous opportunities to improve cancer care for Medi-Cal members.
➢ At present, it is not possible to conclude that Medi-Cal managed care is yielding better health care outcomes.
➢ More effort should be directed toward determining whether Medi-Cal managed care is providing higher quality care at lower cost – i.e., better value.